ATTACHMENT J - ACCOUNTABLE ENTITY TOTAL COST OF CARE REQUIREMENTS

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A. TCOC Definition

Total cost of care (TCOC) is a fundamental element to the Accountable Entity (AE) program. It includes a historical baseline cost of care projected forward to the performance period. Actual costs during the performance period are then compared to this baseline to identify a potential shared savings or risk pool.

Effective TCOC methodologies incentivize AEs to invest in care management and other services that address member needs and reduce duplication of services. In doing so, AEs improve health outcomes, lower costs, and earn savings. Savings in this program are also determined by performance against quality and outcomes metrics.

B. TCOC Methodology Goals

These TCOC guidelines support meaningful performance measurement and create financial incentives to reduce costs and improve quality. In order to accomplish meaningful performance measurement, this methodology:

- **Provides opportunity for a sustainable business model**
  This methodology creates ongoing opportunity for effective AEs by: (1) recognizing efficient historical performers; (2) allowing for shared savings to be retained for system investment; (3) creating greater financial incentives for being inside the AE program than for being outside the program
- **This methodology creates financial flexibility for AEs to** improve clinical pathways for Medicaid high utilizers and to address social drivers of health outcomes and costs
- **Is fiscally responsible for all participating parties** and adequately protect the solvency of the AEs and managed care organizations (MCOs) and the financial interests of the RI Medicaid Program
- **Specifically recognizes and addresses the challenge of small populations** through strategies that minimize the impact of small numbers, given the state's small size
- **Incorporates quality metrics** related to increased access and improved member outcomes
- **Requires timely data exchange and performance improvement reporting between MCOs and AEs.**
- **Includes a progression toward meaningful provider risk**

C. General Requirements for Program Participants

1. **Minimum Membership and Population Size**
   MCOs may utilize TCOC-based payment models only with AEs that have at least 5,000 attributed Medicaid members across all MCOs and at least 2,000 members per MCO-AE contract.

2. **State/MCO Capitation Arrangement**
   The MCO retains the base contract with the State; the MCO medical capitation will be adjusted for savings/risk associated with the program as described in the State/MCO contract. This does not preclude MCOs from creating value-based purchasing arrangements with non-AE providers; however, those contracts would still be subject to the State gain-share and would not be included in the State's assessment of the MCO's value-based payment performance standards related to AEs.

3. **Exclusivity of Approved TCOC Methodologies**
   MCO TCOC arrangements shall supersede and be exclusive of any other TCOC-related shared savings arrangements with an AE or any of its constituent providers for Medicaid members.

4. **Attribution**
   AE specific historic base data must be based on the AE's attributed lives for a given period, in accordance with EOHHS defined attribution requirements, as defined separately. TCOC performance period data must account for and be aligned with the list of attributed members MCOs are required to generate on a monthly basis, as described in the attribution requirements.

D. TCOC Methodology

For PY3, EOHHS has establish a standard methodology for total cost of care. An overview of the methodology is presented here. The full methodology is detailed in the *Total Cost of Care Technical Guidance*.

1. Establishing TCOC targets

For PY3, TCOC targets will include the following components:

- **a.** Historical cost data, including covered services that align with those included in EOHHS's contract with MCOs
- **b.** Adjustment for the changing risk profile of the population
- **c.** Adjustment for trend assumptions
- **d.** Adjustment to historical base relative to market average

2. Measuring Expenditures for the Performance Period

- **a. Calculate Actual Expenditures Consistent with the Historical Base Methodology**
  MCOs will calculate and report actual expenditures for the Performance Period consistent with the base methodology as described above.
- **b. Actual expenditures shall include all performance year costs for those members attributed to an AE**

3. Shared Savings/(Loss) Pool Calculations

The Shared Savings/(Loss) Pool shall be calculated as the difference between Actual

Expenditures and TCOC Expenditure Target after the following adjustments:

a**. Minimum Savings Rate**

EOHHS requires a minimum savings rate (MSR) to limit the potential for Shared Savings payments related to cost reductions generated strictly due to the effect of random variation in utilization and spending in small populations. The MSR by AE size is detailed in the *Total Cost of Care Technical Guidance*.

b. Impact of Quality and Outcomes

The Shared Savings Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. An Overall Quality Score will be generated for each AE, according to the methodology detailed in *Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities.* The Total Shared Savings Pool (inclusive of both the AE and MCO portions) must be multiplied by the Overall Quality Score. The Overall Quality Score must function as a multiplier, and may not include a gate; as such, any quality points earned must be associated with a share of the Shared Savings Pool.

c. Risk Exposure Cap

The Risk Exposure Cap cannot be lower than specified minimum thresholds. The Risk Exposure cap can be expressed as a percentage of the AE-specific TCOC Expenditure Target or as a percentage of the AE's revenue. Savings or losses that exceed 10% in any program year will trigger a review by EOHHS to determine if all Performance Period TCOC and target TCOC calculations are accurate. EOHHS reserves the right to revise any errors and adjust for unforeseen programmatic or data issues that may be contributing to overstated losses or savings.

For AEs assuming downside risk, the Maximum Shared Loss Pool will be defined by the Risk Exposure Cap agreed to by AE and MCO as part of the downside risk arrangement. The Risk Exposure Cap must meet the minimum requirement for transitioning to risk-based arrangements as specified below.

4. AE Share of Savings/(Loss) Pool

In Program Year 3, AEs assuming downside risk must be eligible to retain at least 60% of the Shared Savings Pool and must be responsible for at least 30% of any Shared Loss Pool. AEs in shared savings-only models must be eligible to retain up to 50% of the Shared Savings Pool.

AE Shared Savings Model	AE Share of Savings	AE Share of Losses
Shared savings only	Up to 50% of Shared Savings Pool	N/A
Shared savings and risk	At least 60% of Shared Savings Pool	At least 30% of Shared Loss Pool

5. Required Progression to Risk-Based and Value-Based Arrangements

a. AEs qualified to assume downside risk

Certified AEs qualified to assume downside risk must demonstrate a progression of risk to include meaningful downside shared risk within three years of AE program participation. New participants in the AE program begin this progression at Year 1 levels of risk exposure and risk sharing.

EOHHS has defined "meaningful risk" based on learnings from other states, OHIC requirements and federal MACRA rules. The required progression of increasing risk for AEs qualified to assume downside risk is as follows:

	Shared Savings Cap *Maximum Shared Savings Pool*	**Risk Exposure Cap** *Maximum Shared Loss Pool*	**Risk Sharing Rate** *AE Share of Losses*
Definition	*A cap on the Shared Savings Pool, expressed as a percentage of the total cost of care*	*A cap on the Shared Loss Pool, expressed as a percentage of a) the total cost of care, or b) the annual provider revenue from the insurer under the contract*	*The percentage of the Shared Loss Pool shared by the provider with the insurer under the contract after the application of the risk exposure cap*
Year 1	At least 10% of TCOC	N/A	0
Year 2	At least 10% of TCOC	N/A	0
Year 3	At least 10% of TCOC	**At least** the lesser of 1% of TCOC; or 3% of AE Revenue	At least 30%
Year 4	At least 10% of TCOC	**At least** the lesser of 2% of TCOC; or 6% of AE Revenue	At least 40%
Year 5	At least 10% of TCOC	**At least** the lesser of 3% of TCOC; or 8% of AE Revenue	At least 50%

For Program Year 3, EOHHS has aligned minimum downside risk requirements proportionally with the most marginal risk standards established by the Office of the Health Insurance Commissioner (OHIC). Alternative risk requirements for larger organizations may be considered in the future as AEs develop risk-bearing capacity.

Additionally, approved TCOC contracts for Program Year 3 that include downside risk must be pre-qualified by OHIC to ensure that an AE has a risk mitigation plan sufficient to cover its maximum possible loss under such a contract. Details of OHIC's pre-qualification process for risk-bearing provider organizations is found in *Attachment B: Pre-Qualification of Accountable Entities Bearing Financial Risk.*

b. AEs not eligible to assume downside risk

In accordance with CMS guidance, EOHHS must ensure that Federally Qualified Health

Centers receive and retain 100% of the Medicaid payments and cannot be put at risk for receiving less than PPS for FQHC services. Therefore, FQHC AEs may remain in shared savings-only contracts if they progress towards value-based care and alternative payments as evidenced by an EOHHS-approved proposal demonstrating a positive ROI. Such proposals may include the development of evidence-based processes, incentives for cost reduction, and the establishment of sustainability for interventions currently funded by grants; these proposals are also outlined in *"ATTACHMENT K – INFRASTRUCTURE INCENTIVE PROGRAM: REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND CERTIFIED ACCOUNTABLE ENTITIES."*

E. TCOC Reporting Requirements

In order to monitor AE financial performance, MCOs are required to furnish to EOHHS and AEs on a quarterly basis reports regarding TCOC performance. The reports must include, by rate cell, summarized TCOC expenditures and member months for attributed members over a recent 12-month period.

Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities

A. Principles and Quality Framework

A fundamental element of the EOHHS Accountable Entity (AE) program, and specifically the transition to alternative payment models, is a focus on quality and outcomes. Measuring and rewarding quality as part of a value-based model is critical to ensuring that quality is maintained and/or improved while cost efficiency is increased. As such, the payment model must be designed to both recognize and reward historically high-quality AEs while also creating meaningful opportunities and rewards for quality improvement. This model must be measurable, transparent and consistent, such that participants and stakeholders can view and recognize meaningful improvements in quality as this program unfolds.
The Program requirements are intended to provide structure that permits baseline measurement and assessment, while allowing for future refinements that continuously "raise the bar" toward critical improvements in quality and outcomes.

B. Shared Savings Opportunity

Medicaid AEs are eligible to share in earned savings based on a quality multiplier (the "Overall Quality Score") to be determined as follows:

- The AE must meet the established total cost of care (TCOC) threshold as determined using the EOHHS approved TCOC methodology to be eligible for shared savings.
- In accordance with 42 CFR §438.6(c)(2)(ii)(B)[1], quality performance measurement must be based on the Medicaid Accountable Entity Common Measure Slate. EOHHS expects that performance on each measure be reported annually for the full quality measure performance year.
- For comprehensive AEs, all admin (claims-based) measures must be generated and reported by the MCO. AEs must provide the necessary data to the MCO to generate any hybrid or EHR-only measures. Any EHR-only non-HEDIS measure is defined to include only active patients in the denominator. Active patients are individuals seen by a primary care clinician associated with the AE anytime within the last 12 months.
- An Overall Quality Score must be generated for each AE. The Overall Quality Score will be used as a multiplier to determine the percentage of the shared savings pool the AE and MCO are eligible to receive. Overall Quality Scores must be calculated distinctly for each MCO with which the AE is contracted.
- Performance year periods, which are aligned with the state fiscal year calendar, will be tied to the calendar year quality performance period ending within the performance year period. The prior calendar year quality performance period will serve as the benchmark period, as shown below.

Performance	Performance	Quality	Quality	Payment

1. https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8

Year	Time Period	Measurement Performance Period	Measurement Benchmark Period	
PY 1	SFY 2019	HEDIS 2019, CY 18	HEDIS 2018, CY 17	SFY 2020
PY 2	SFY 2020	HEDIS 2020, CY 19	HEDIS 2019, CY 18	SFY 2021
PY 3	SFY 2021	HEDIS 2021, CY 20	HEDIS 2020, CY 19	SFY 2022
PY 4	SFY 2022	HEDIS 2022, CY 21	HEDIS 2021, CY 20	SFY 2023

C. Medicaid AE Common Measure Slate for Comprehensive AEs

In accordance with 42 CFR §438.6(c)(2)(ii)(B)[2], quality performance measurement must be based on the Medicaid Comprehensive AE Common Measure Slate (see Section F below). The 12 core measures must be reported for all measure that meet the eligible denominator sizes. The Common Measure Slate for comprehensive AEs has been developed with the following considerations:

- Alignment with the RI OHIC core measure set.
- Cross cutting measures across multiple domains with a focus on clinical/chronic care, behavioral health, and social determinants of health.
- Feasibility of data collection and measurement and minimization of administrative burden.
- A minimum number of measures necessary to enable a concentrated effort and meaningful assessment of quality.
- Focus on statewide strategic priorities outlined by EOHHS, RI Department of Health, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and the Office of the Health Insurance Commissioner.

D. Comprehensive AE Overall Quality Score Determination

As articulated in the Rhode Island Accountable Entity Program Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities: Implantation Manual hereafter referenced as "Implementation Manual", EOHHS developed a standard quality score methodology to be used by all AEs and MCOs.
The required TCOC Overall Quality Score methodology is as follows:

1. **Target Structure:** The Overall Quality Score recognizes AEs that either attain a high-achievement target or demonstrate a required level of improvement over prior performance. MCOs will assess AE performance on each Common Measure Slate P4P measure for both achievement and improvement. For each Common Measure Slate measure except SDOH Screening, AEs will be awarded whichever score yields the greatest performance points. The maximum earnable score for each measure will be "1", and each measure will be weighted equally.

2. https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8

a. Achievement targets:
    i. EOHHS will establish two achievement targets: "threshold" and "high."
    ii. Achievement points will be scored on a sliding scale for performance between the threshold and high values.
        1. If performance is below or equal to the threshold-performance target: 0 achievement points
        2. If performance is between the threshold-performance and the high-performance target, achievement points earned (between 0 and 1) will be determined based on the following formula: (Performance Score – Threshold Performance) / (High-Performance Target –Threshold Performance)
        3. If performance is above the high-performance target: 1 achievement point
b. Improvement target:
    i. The improvement target will be a fixed number of percentage points, with three percentage points as the default value.
        1. The value may vary from three percentage points if deemed appropriate by EOHHS.
        2. The value may be less than what would be required to demonstrate statistical significance in a given year.
    ii. Improvement will not be recognized by the MCO if the rate is statistically significantly below the rate of two calendar years prior[3].
    iii. Improvement as defined by 1.b.i and 1.b.ii will earn the AE a score of "1."

2. **Scoring SDOH Screening, SDOH Infrastructure Development, and Screening for Clinical Depression and Follow-up Plan**: These three measures will be scored differently than the other Common Measure Slate measures for QPY3. There will be neither an achievement nor improvement assessment for these measures. Instead, these three measures will be treated as follows:
    - SDOH Screening: Reporting-only measure with no Overall Quality Score Implications for QPY3.
    - SDOH Infrastructure Development**:** AEs will have the opportunity to earn a score of "1" if the percentage of attributed patients whose primary care clinician's EHR contains a defined field that indicates whether a social determinants of health screen was completed equals or exceeds 50%. If the AE does not report the measure, or if the resulting measure performance is less than 50%, it will earn a score of "0."
    - Screening for Clinic Depression and Follow-Up Plan: AEs will have the opportunity to earn a score of "1" if they report performance on the measure. If the AE does not report the measure, it will earn a score of "0."

E. Calculation of the Overall Quality Score and TCOC Quality Benchmarks

Each MCO will sum the points earned across all measures for which the AE has an adequate denominator size[4] and divide that sum by the number of measures for which there is an adequate denominator size. For example, if an AE has an adequate denominator size for all AE Common Measure Slate measures, then the MCO would sum the scores for each of the ten measures and divide the result by 10[5]. This resulting quotient is the "Overall Quality Score." The MCO shall multiply the annual savings or loss generated by the AE by the Overall Quality Score to determine the shared savings to be distributed to the AE, or loss to be shared with the AE.

EOHHS will define the percentage of quality measures from the common measure slate needed to achieve full shared savings (or to fully share losses) once QPY1 AE performance data and NCQA HEDIS benchmarks for CY2018 are available. EOHHS anticipates completing this process by November 30, 2019. Please refer to the Implementation Manual for further details. **In setting this parameter, EOHHS' general principle is that AEs should be allowed to achieve the full share of shared savings (or losses) without having to earn the maximum possible points, i.e., through hitting the high achievement or improvement targets for all ten measures.**

EOHHS will employ a combination of internal and external sources to set achievement targets:

a. Set interim targets for Quality Performance Year 3 using Quality Performance Year 1 data (in conjunction with the other sources listed below) in advance of Quality Performance Year 3, and
b. Set final Quality Performance Year 3 targets using Quality Performance Year 2 data (in conjunction with the other sources listed below) once they become available.

AE Quality Performance Year 1 and 2 data will be used to ensure the following guiding principles are met: 1) the high achievement target should be attainable for at least some AEs; 2) the high achievement target should not exceed a value that represents a reasonable understanding of "high performance"; and 3) the high achievement target should not be below the current performance of every single AE.

EOHHS will also consider the following benchmark sources:

a. <u>HEDIS measures</u>
    i. NCQA's Quality Compass benchmarks will be used whenever possible, for QPY3, HEDIS 2019 (CY2018) will be used. The benchmark (e.g., 75th percentile for Medicaid managed care) used to set achievement targets will vary by measure based on EOHHS assessment of past MCO or AE performance.
b. <u>Non-HEDIS measures</u>

ii. Alternative sources to NCQA's Quality Compass will be used for non-HEDIS measures as available for the measure.
iii. For QPY3, EOHHS will use OHIC-gathered Rhode Island PCMH 10/18-9/19 performance measure data for benchmarking purposes. These data are collected annually by OHIC from primary care practices seeking OHIC PCMH designation (171 practices submitted in 2018). OHIC data can be stratified to identify Medicaid-focused practices (i.e., self-reported to have >50% of patients covered by Medicaid or be uninsured), although the absolute number of such practices has historically been low.

Should benchmark data be unavailable for a given measure, EOHHS will convene a meeting of AEs, MCOs, and clinicians to review the measure and determine appropriate benchmarks.

F. Comprehensive AE Common Measure Slate*

Measures[6]	Steward	Data Source[7]	Specifications	AE Common Measure Slate		
				QPY1	QPY2	QPY3
HEDIS Measures						
Adult BMI Assessment	NCQA	Admin/Clinical	Current HEDIS specifications: QPY1: HEDIS 2019 QPY2: HEDIS 2020 QPY3: HEDIS 2020* *A work group of AE and MCO participants shall convene once HEDIS 2021 specifications are released to approve adoption of HEDIS 2021 specifications for use in QPY3.	P4R	P4P/P4R	
Adolescent Well-Care Visits	NCQA	Admin/Clinical				P4P
Breast Cancer Screening	NCQA	Admin		P4R	P4P	P4P
Comp. Diabetes Care: Eye Exam	NCQA	Admin/Clinical				P4P
Comp. Diabetes Care: HbA1c Control (<8.0%)	NCQA	Admin/Clinical		P4R	P4P/P4R	P4P
Controlling High Blood Pressure	NCQA	Admin/Clinical		P4R	P4P/P4R	P4P
Follow-up after Hospitalization for Mental Illness	NCQA	Admin		P4R – 7 or 30 days	P4P – 7 or 30 days	P4P – 7 days
Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents	NCQA	Admin/Clinical		P4R	P4P/P4R	P4P
Non-HEDIS Measures (Externally Developed)						
Developmental Screening in the 1st Three Years of Life	OHSU	Admin/Clinical	QPY1-3: CTC-RI/OHIC (December 2018 version)[8]	P4R	P4P/P4R	P4P
Screening for Clinical Depression and Follow-up Plan	CMS	Admin/Clinical	QPY1: CMS MIPS 2018[9] Depression QPY2: CMS MIPS 2019[10]	P4R	P4P/P4R	P4R[12]

*Measures are subject to change based on the recommendations of OHIC's Measure Alignment Review Committee

[6] Attachments L1 for Program Years 1 and 2 included Self-Assessment/Rating of Health Status as developed by EOHHS. This measure is no longer part of the AE Common Measure Slate for QPY1-3. EOHHS communicated its decision to drop this measure from Program Year 2 in its 4/30/19 amended Attachment L1.

[7] "Admin/Clinical" indicates that the measure requires use of both administrative and clinical data.

[8] http://www.ohic.ri.gov/documents/Revised-Measure-Specifications-Adult-and-Pedi-CTC-OHIC-Dec-2018-FINAL.pdf

[9] https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2018#measures

[10] https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019#measures

[12] EOHHS has decided to make Screening for Clinical Depression and Follow-up Plan P4R in QPY3 so it can better understand the impact on performance of the significant changes in the 2019 technical specifications.

Measures[6]	Steward	Data Source[7]	Specifications	AE Common Measure Slate		
				QPY1	QPY2	QPY3
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	Admin/Clinical	Tobacco QPY2: CMS MIPS 2018[11] QPY3: CMS MIPS 2020	P4R	P4P/P4R	Reporting-only
Non-HEDIS Measures (EOHHS-developed)						
Social Determinants of Health Screening	EOHHS	Admin/Clinical	QPY1-2: EOHHS February 15, 2018 version[13] QPY3: EOHHS a July 8, 2019 version – included as Appendix A	P4R	P4R	Reporting-only
Social Determinants of Health Infrastructure Development	EOHHS	Admin/Clinical	QPY3: EOHHS (July 23, 2019 version – included as Appendix B)			P4P
Optional Measure Slates (for QPY1 and QPY2 EOHHS permits selection of up to 4 optional measures)[14]						
OHIC Aligned Measure Set Menu			QPY1: OHIC 2018[15] QPY2: OHIC 2019[16]	P4R/P4P	P4R/P4P	
CMS Medicaid Adult Core Set			QPY1: CMS 2018[17] QPY2: CMS 2019[18]	P4R/P4P	P4R/P4P	
CMS Medicaid Child Core Set			QPY1: CMS 2018[19] QPY2: CMS 2019[20]	P4R/P4P	P4R/P4P	

[11] Tobacco Use: Screening and Cessation Intervention had substantive changes in the CMS MIPS 2019 version.
[13] http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Final%20Documents/SDOH%20Guidance%20Document%202018-02-15.pdf
[14] Optional Admin measures must be pay-for-performance in QPY1. Optional Admin/Clinical or Clinical-only measures may be pay-for-performance or pay-for- reporting in QPY1.
[15] http://www.ohic.ri.gov/documents/Crosswalk%20of%20RI%20Aligned%20Measure%20Sets%202017%2011-2.xlsx
[16] http://www.ohic.ri.gov/documents/Crosswalk-of-RI-Aligned-Measure-Sets--For-2019-2018-10-13.xlsx
[17] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-adult-core-set.pdf
[18] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf
[19] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf
[20] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf

Attachment B: Pre-Qualification of Accountable Entities Bearing Financial Risk

1 Background

In order to ensure that those Accountable Entities assuming downside risk in their contracts with MCOs in PY3 (July 1, 2020 through June 30, 2021) are prepared to do so, EOHHS will require AE participation in a pre-qualification process. The Office of the Health Insurance Commissioner (OHIC) will conduct these reviews on behalf of EOHHS. AEs anticipating any downside risk in their contracts with MCOs in PY3 will be required to submit the pre-qualification application and supporting documentation (detailed below) to OHIC by January 15, 2020. OHIC will complete its review by March 15, 2020 and may "pre-qualify" an AE as having the financial capacity to bear an estimated amount of downside risk (across Medicaid MCO contracts) that the AE anticipates assuming in PY3.

For PY4 a financial solvency filing process and review will commence to certify AEs for downside risk. This review will include an assessment of the AE's solvency in the context of the actual PY3 and PY4 AE/MCO contract terms with downside risk, and the AE's vehicles for mitigating such risk. The details of the financial solvency filing process and review will be forthcoming.

a. AEs that Must File for Pre-qualification

OHIC will maintain a single pre-qualification review process for all AEs that will be entering into arrangements that include shared losses. This review will estimate the amount of downside risk the AE anticipates assuming in PY3 and whether the AE has an adequate combination of assets and insurance to cover the maximum risk exposure.

b. Requirements for Pre-qualification

EOHHS will allow for flexibility in AEs' approaches to managing their risk exposure as long as the AE can document a thorough strategy for obtaining protection from estimated maximum potential losses. If an AE has a strong balance sheet, its strategy for covering maximum potential losses due to downside risk could include documenting that it has sufficient existing secured liquid assets and reinsurance to cover the maximum potential losses. Other organizations without available liquid assets to cover the maximum potential losses may need to develop a risk strategy portfolio consisting of several different approaches. Strategies could include, for example, aggregate and individual stop loss insurance, corporate investors, provider partner organization contributions, insurer withholds, delegation of risk to contracted provider organizations, insurer-provided capital, securities in trust, and letters of credit.

For AEs without the necessary secured liquid assets to cover their estimated maximum potential loss, OHIC will require provision of copies of any agreements with organizations assuming some or all of the risk on behalf of the AE. Such agreements should, at a minimum, detail the financial arrangement, and the amount of risk being assumed by each organization. OHIC will require that each AE submit documentation that it has taken adequate steps to cover the risk using a) secured assets in a custodial or controlled account(s),

and/or b) a reinsurance policy which can be used to protect the interests of enrolled Medicaid members, and/or c) delegation of risk to one or more parties. Taken together, the value of these strategies should not be less than the potential maximum losses due to all downside risk contracts with Medicaid MCOs.

As part of the pre-qualification application, AEs will also be required to submit a planned process for ongoing monitoring of performance against the downside financial risk arrangements for the AE and any subcontracted entities assuming delegated risk.

c. Process for Review

The process that OHIC will follow in its review is outlined below in i-viii.

i. The AE submits its application to OHIC with all supporting documentation by January 15, 2020.

ii. OHIC determines the AE's actual and/or estimated maximum risk exposure for MCO contracts for PY3.

iii. OHIC determines whether the AE has an adequate current or planned process for ensuring sufficient financial resources to protect it, and those entities with which it has a contracting affiliation and is sharing or intends to share downside risk, from the estimated maximum potential losses from all Medicaid MCO contracts with downside risk with one or more financial mechanisms (e.g., liquid assets, stop-loss insurance, working capital and reserves, withhold arrangements or other financial mechanisms).

iv. OHIC ensures that if the AE has liquid assets as part of its current or planned process to protect itself from the maximum potential losses, that the liquid assets are in a custodial or controlled account, which can be used exclusively to protect the interests of attributed Medicaid patients.

v. OHIC reviews the AE's current and/or planned process for ongoing monitoring of performance against downside financial risk arrangements and assurance of financial solvency and ensures that the process is acceptable.

vi. OHIC reviews the AE's current and/or planned process for ongoing monitoring of any subcontracted provider entities assuming AE-delegated downside risk and ensures that process is acceptable.

viii. EOHHS notifies the AE by March 15, 2020 of its pre-qualification status. AEs can appeal the decision, in writing to EOHHS, within 30 days of its notification. AEs that choose not to appeal the decision but who would like to reapply for pre-qualification can do so by re-submitting the application and supporting documents addressing the concerns highlighted by OHIC in the original application.

If at any time during its review OHIC determines that it requires additional documentation, it will notify the AE in writing specifying the additional documentation needed.

d. Pre-qualification Application Materials

Medicaid Accountable Entity Pre-qualification Application

1. AE Descriptive Information

Rhode Island Medicaid Accountable Entity Organization Information

Name of Applicant:_____

The following information is required of the individual (within the Accountable Entity) who is designated to be the AE's primary contact for the pre-qualification process:

Title:_____

First Name:_____ Last Name:_____

Position: _____

Street or PO Address:_____

City:_____ State:_____ Zip Code:_____

E-mail Address:_____

Telephone:_____

2. Provide a list of the names of the Medicaid MCOs with which the applicant will be entering into an arrangement to assume financial accountability for the full range, or nearly the full range, of an attributed MCO member population's health care needs.

   Please include contracts that will start in 2020. If contract negotiations are underway at the time of the application or are anticipated to begin but have not yet, indicate the status of negotiations and report anticipated risk arrangement terms. Notify OHIC within 30 days after the contract is executed with the final risk arrangement terms of each contract using an amended version of the table below.

   a. For each MCO contract, provide the nature of the reimbursement arrangement and the estimated number of attributed patient lives in PY3.

Name of MCO	Risk Arrangement Terms	Aggregate Number of Attributed Patients and Associated Date
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM Budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	

3. Provide a statement that describes the applicant's experience to date in managing population-based contracts that hold the applicant organization financially responsible for a negotiated portion of costs that exceed a predetermined population-based total cost of care (TCOC) budget.

   _____
   _____
   _____

4. Please attach a plan that provides details of the applicant's planned process and mechanism(s) for ensuring sufficient financial resources to protect the applicant and those provider entities with which it has a contracting affiliation and intends to share downside risk, from the estimated potential maximum losses from downside risk associated with MCO contract(s).

   - Distinguish current liquid assets from other mechanisms, including insurance coverage or other agreements that protect the applicant from potential maximum losses from future downside risk. If liquid assets are being used to protect the applicant from maximum potential losses, please provide evidence that the funds are in a controlled or custodial account to be used exclusively to protect the interests of attributed Medicaid patients.
   - If the applicant intends to utilize current liquid assets to cover a potential maximum loss, please provide the financial statement of the applicant and/or any other entity whose assets might be utilized to cover the loss.
   - If the applicant is planning a financial arrangement with any partner organization(s) that is assuming any of the applicant's downside risk, the partner(s) must execute a Parental Guarantee[21] document prior to applying for pre-qualification from OHIC.

5. Include a description of the applicant's current or planned process for ongoing monitoring of the applicant's financial risk arrangements and financial solvency.

6. Include a description of mechanisms that are or will be put in place by the applicant to monitor the financial solvency of any provider entity(ies) with which it has a contracting affiliation and intends to share downside risk associated with MCO contract(s).

[21] A Parental Guarantee is an agreement between an entity that controls a health care provider and the health care provider. It guarantees the performance of the provider's obligations under the financial risk transfer agreement including the payment of any amounts owed by the health care provider to participating providers for services rendered pursuant to a risk transfer agreement.

Glossary of Terms

Parental Guarantee - An agreement between an entity that controls a health care provider and the health care provider. It guarantees the performance of the provider's obligations under the financial risk transfer agreement including the payment of any amounts owed by the health care provider to participating providers for services rendered pursuant to a risk transfer agreement.

Partner Organization - An entity that will be assuming some of the AE's downside risk. It may be, but is not limited to, a corporate parent or otherwise related corporate entity, an investor, a business partner, or a delegated provider entity that delivers health care services to the AE's attributed patients. A delegated physician or other professional provider is not a partner organization if the totality of its assumption of AE risk is borne through a payment withhold.

PMPM (Per Member Per Month) Budget – A prospectively defined spending target associated with an Accountable Entity's (AE) attributed population, wherein spending is defined on an average monthly per capita basis, or "per member per month."

Provider Revenue – This is the total annual service revenue, care management and infrastructure payments accruing to the provider for attributed members under the contract. This should be reported for those contracts that employ a risk exposure care based on provider revenue.

Risk Exposure Cap - Also called Maximum Shared Loss Pool. This is a cap on the losses the organization may incur under the contract, expressed as a percentage of a) the total cost of care or b) the annual service revenue from the insurer under the contract. It is the maximum percentage of the organization's contract revenue for which the organization is financially at risk.

Risk Sharing Rate - Also called the Marginal Risk. This is the percentage of total losses shared by the organization with the insurer under the contract after the application of any risk exposure cap and/or minimum loss rate. It is the percentage of any Shared Loss Pool for which the organization is financially at risk.

Stop Loss Insurance (aggregate/specific) - Aggregate stop-loss insurance is a policy designed to limit claim coverage (losses) to a specific amount. This coverage ensures that a catastrophic claim (specific stop-loss) or numerous claims (aggregate stop-loss) do not drain the financial reserves of the organization.

Total Cost of Care - A historical baseline or benchmark cost of care specifically tied to an Accountable Entity's (AE) attributed population projected forward to the performance period.

Withhold Arrangement - A withhold arrangement is characterized by the insurer withholding the amount of money at risk until the contracting organization furnishes services to the members and meets certain quality and/or cost standards.